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No. 99-936

IN THE

Supreme Court of the United States

CRYSTAL M. FERGUSON, *et al.*,
Petitioners,

v.

THE CITY OF CHARLESTON, SOUTH CAROLINA, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

Motion of the American Public Health Association, South Carolina Medical Association, American College of Obstetricians and Gynecologists, American Nurses Association, *et al.*, for Leave to File Brief as *Amici Curiae* and Brief *Amici Curiae* In Support of Petitioners [additional *Amici* listed on inside front cover]

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MOTION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, *ET AL.*, FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Sup. Ct. Rule 37.2(b), *Amici* – physicians, nurses, public health officers, substance abuse treatment professionals, and medical researchers from around the country, and their professional associations – move for leave to file the attached brief *Amici Curiae* in support of Petitioners seeking review of Ferguson v. City of Charleston, 186 F.3d 469 (4th Cir. 1999).

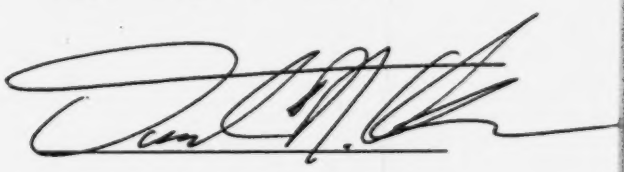
In the decision below, a divided panel of the Fourth Circuit upheld a governmental policy whereby the trust inherent in the relationship between the patient and the treatment provider was manipulated by law enforcement authorities to obtain bodily fluids from indigent pregnant women for use as incriminating evidence. The parties and both courts below

recognized that the constitutional issues presented by the policy in this case cannot properly be decided in isolation from the scientific, medical, and public health context from which the policy arose.

Amici have recognized expertise in the areas of the physician-patient relationship, the need to maintain the confidentiality of personal medical information, maternal and neonatal health, and the treatment and prevention of substance abuse among pregnant and parenting women. This brief is offered to illuminate the basic medical misunderstandings that infected the decision below, and to alert this Court to the unwelcome uncertainty that the panel majority has injected into the treatment provider-patient relationship, and to the real harms that this uncertainty can cause individuals, their families and their communities.

This motion is necessary because Respondents have declined to consent to the filing of this brief *Amici Curiae*.

Respectfully submitted,



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INTEREST OF *AMICI CURIAE*[*]

All parties and both courts below recognized that the legal issues presented by the policy at issue in this case cannot properly be decided in isolation from the scientific, medical, and public health context from which the policy arose. The resolution of these issues necessarily depends on an understanding of this context, and how this Court decides those issues could have direct and deleterious consequences for health and health care.

Amici are physicians, nurses, public health officers, substance abuse treatment professionals, and medical researchers, as well as state, local, and national medical and professional associations, with longstanding interest in and understanding of issues of substance abuse, pregnancy, neonatal health, and medical ethics.[1] While there is great variety among *Amici* as to experience, expertise, and perspective on medical, scientific, and public health issues, *Amici* are united in their condemnation of the policy implemented at the Medical University of South Carolina in Charleston ("MUSC") and the judicial decision approving it. They join together in this brief to explain how the policy lacks foundation in medicine and science and to inform this Court of the dangers the decision below portends for treatment professionals and their patients.

PRELIMINARY STATEMENT

As will be explained, *Amici* are firmly convinced, based on years of clinical experience and rigorous scientific study, that policies such as the one at issue in this case are medically

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[*] No entity or counsel apart from those whose names appear on this Brief have contributed monetarily or substantively to its production. Sup. Ct. R. 37.6.

[1] Descriptions of the *Amici* are set forth in the Appendix to this brief.

unsound and yield adverse health consequences, including for – indeed, especially for – the women and children in whose interests they are purportedly carried out.

Amici are especially troubled by the law enforcement rules that governed the medical and hospital personnel under the policy at issue in this case. The policy's purported concern for maternal and fetal health should not, in and of itself, excuse incursion into Petitioners' basic privacy rights as a matter of medical practice, professional ethics, and law.

Indeed, for all the professed concern for health, the policy showed a deplorable lack of interest in the medical, psychological, and behavioral problem it sought to address – substance abuse – and a surprising incuriosity about whether the approach taken – which placed patients at risk of years of incarceration – had any prospect of achieving its avowed purpose.

The decision below, though evidently influenced by medical considerations – to the point of excusing Defendants from Fourth Amendment responsibility based on their health-related motivations – has unsettled not only the law of Search and Seizure but also key understandings governing both the pursuit and provision of health care. Specifically, the appellate court's approval of the policy as constitutional and reasonable has injected unwelcome uncertainty into doctor-patient relationships, especially those involving patients at risk of criminal liability and has, in the name of advancing health interests, complicated the relationship between the health care system and the criminal law.

Although *Amici* believe it is important that legal rules appreciate the nature of medical practice, judicial solicitude of the sort exhibited by the decision below can only be appropriate, if at all, when physicians are truly engaged in medical treatment, *i.e.*, when exercising independent professional judgment, subject to the full range of ethical

restraints and responsibilities. When, as here, physicians, nurses, and hospital administrators are compelled to abdicate their professional roles and assist in a campaign to arrest and prosecute their patients, the dangers to individual freedom multiply, and special vigilance – not solicitude – from the judiciary is in order.

SUMMARY OF ARGUMENT

As this Court has long recognized, the imperatives of the practice of medicine and those of the legal system do not always travel together. This case, however, presents no such tension. Here, the central concerns of the Fourth Amendment in securing the individual against improper governmental intrusions on personal privacy, the basic tenets of professional ethics directing that health care providers uphold the trust and confidence placed in them by patients, and society's strong interest in promoting public health all teach the same lesson: government physicians and nurses should not act as agents of law enforcement, nor should they use "routine" medical examinations to covertly gather evidence for use against patients in criminal proceedings.

Rather than perceive the special dangers that inhere when law enforcement officers make hospital decisions and require health care providers to help build prosecutors' cases against their patients, the decision below took a very different view. The panel majority essentially assumed that the physicians' and nurses' participation in the challenged policy somehow diminished the potency of the constitutional threat. Thus, the court below applied a more forgiving, "special needs" standard to the policy at issue. In deciding that the policy would only be reviewed for its "reasonableness," the Court of Appeals pointed both to the presumed motives of the governmental actors responsible, *i.e.*, the court's belief that concern for fetal health (and not "vindictiveness") animated their actions, and to their professional identities, *i.e.*, the fact

that many of the governmental actors who carried out the policy wore doctors' and nurses' uniforms, rather than those of police officers.

Taken separately or together, *Amici* submit, these considerations should not have excused Defendants from compliance with the privacy protections the Fourth Amendment presumptively imposes on law enforcement efforts. First, "good" motives, including the asserted concern for health, may not in themselves exempt a policy from otherwise applicable Fourth Amendment requirements. If the less demanding "special needs" exception were triggered whenever government actors could show that their ultimate concern was for the well-being of the person searched, or that of a third party, little would remain of the constitutional "rule," that the absence of probable cause or a warrant renders a search unconstitutional *per se*. Indeed, the answer to any suggestion that well-intentioned government actions should be subject to more forgiving Fourth Amendment scrutiny was forcefully stated many years ago:

> Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well meaning but without understanding.

Olmstead v. United States, 277 U.S. 438, 485 (1928) (Brandeis, J., dissenting).

Nor was the decision below correct to assume that the conscription of government-employed health professionals to carry out the policy automatically imparted to it a "medical" or therapeutic character, let alone one that provided benefits to parents, children or society. On the contrary, the policy required physicians and nurses to choose between their loyalty

to patients and their obligation, as law-abiding citizens, to follow the policy implemented by law enforcement officials at the Medical University of South Carolina. This policy depended at its core on compelling health care professionals to abandon their duties to patients. It is evident that the policy's stated aim of "changing human behavior through legal intervention" could hardly have been attempted without a broad suspension of ethical obligations – including, among others, the core duties to deal honestly with patients, to safeguard their confidences, and to advocate on patients' behalf.

Nor could the policy rightly be described as "medical," based on its understanding of the problem and choice of approach. Although substance abuse treatment may not be a field characterized by lockstep uniformity of professional judgment, the policy at issue here departed drastically from a basic, widely shared understanding of what may be considered medically responsible "treatment." The core premise of the policy – that the patients who sought prenatal care could stop themselves from ingesting drugs simply as a result of being warned of the negative consequences that could befall them (or their children), or by being threatened with even more dire consequences – is wholly inconsistent with medical knowledge about drug dependency, its causes and most promising treatment approaches. Indeed, the policy was formulated in defiance of the counsel of the independent substance abuse treatment expert, Dr. Ira Chasnoff, whose input Defendants had solicited.

No effort was made to verify untested initial hunches about the scope or seriousness of the problem of *in utero* exposure to cocaine or the validity of the criteria for selecting the patients who were to be tested. No effort was made to properly assess the scope and severity of the substance use of the women who tested positive for cocaine, or to tailor treatment options to the particular needs of individual patients.

And no effort was made to incorporate therapeutic approaches that in 1988 already had been shown to be particularly effective with pregnant drug-dependent women. At its inception, the policy provided for arrest of women who had been denied any real option to obtain treatment, and when a "treatment" element was belatedly inserted into the policy (in apparent response to concerns about unfairness), it was manifestly unsuited to the medical needs of the individuals involved.

The policy at issue and the judicial decision upholding its legality share a defining error: the failure to take account of the special ethical and medical significance of the relationship between patient and health care provider. While the ethical duties of honesty and confidentiality ultimately rest on principles of morality, their practical importance to the daily delivery of health care is immense. Competent health care cannot be rendered unless a patient trusts her care giver sufficiently to share medically relevant, but potentially embarrassing (or incriminating) information; or, for that matter, unless she is willing to see a treatment provider in the first place. This necessary trust does not attach automatically. It must be earned and sustained. The challenges of establishing this relationship are particularly formidable where a patient is indigent, drug-dependent, or pregnant; or, as we [illegible] many Petitioners here, all three. Research and clinical experience teach that when, as here, the personal risks of seeking medical care are raised to intolerably high levels, it is more likely that prenatal care and patient candor – and not drug use – will be what is deterred, often with tragic health consequences.

As with the policy itself, the decision to uphold the policy's reasonableness evinced scant regard for the importance of the treatment provider-patient relationship. Both that decision's assertion that the burden on individual privacy involved here was "minimal" and its finding that the policy was in the "public interest" ignored the real dangers posed to this

relationship. Indeed, its notion that urine tests have become a "routine part of a medical examination" presupposes the very relationship built on trust and confidence that the policy did much to unravel. Similarly, it was only by ignoring the critical defects of the policy and by draining the term of its ordinary meaning that the decision below was able to pronounce the policy "effective" as a matter of constitutional law.

Finally, explicit in Respondents' defense of the policy and (at least) implicit in the "special needs" conclusion of the Fourth Circuit were assumptions that (1) exposure to cocaine *in utero* presents health risks different in kind from those threatened by ingestion of other legal and illegal substances and (2) the policy challenged here was truly a last resort, indeed the "only effective treatment" available. In point of fact, Defendants' policy was neither "treatment" nor "effective" treatment, and any implication that more accepted medical approaches had been tried and failed is simply incorrect.

To the extent that the decision below construed "beyond the normal needs of law enforcement" to mean that maternal cocaine use was uniquely dangerous "criminal" behavior, against which ordinary law enforcement tools were impotent, that assessment was erroneous. Although *Amici* do not wish to minimize the risks posed by *in utero* exposure to different substances, whether alcohol, tobacco, cocaine, excessive sweets, salts, etc., or in having this Court opine on unresolved scientific questions relating to the relative risks posed by different substances, it is important to note the lack of scientific basis, in 1989 through to the present, for the assumption that so plainly animated the policy and its defense: that the dangers of maternal cocaine use are fundamentally different from or more serious than other behaviors that may pose risk of fetal harm. Without denying the obvious advisability of protecting infants from exposure to potential teratogens, scientific research is increasingly finding that the alleged "crack baby" crisis that

impelled prosecutors to override the ethical responsibilities of physicians and nurses to patients, was drastically overstated.

ARGUMENT

I. Medical Personnel Involvement Does Not Justify Relaxing Fourth Amendment Requirements

A. Prosecutors' Purported "Health" Motivations Cannot Excuse Searches Conducted Without Warrants and Probable Cause

To the extent that the decision below held that "medical" motives sufficed to trigger the "special needs" analysis, little discussion is required to show that to be error. If only police and prosecutors had been involved, the fact that particular individuals among them were "motivated by a desire to protect the health of children born at MUSC" would have scant, if any, Fourth Amendment significance. To the contrary, it is black letter law that government actors' subjective motives are irrelevant under the Fourth Amendment, see Whren v. United States, 517 U.S. 806 (1996), and it is no more plausible that "good intentions" could redeem a legally unreasonable search than that "[s]ubjective intent alone . . . [could] make otherwise lawful conduct illegal or unconstitutional." Scott v. United States, 436 U.S. 128, 138 (1978).

Indeed, if concern for third-parties' well-being were sufficient to trigger the "narrow" "special needs" exception, very little would remain of the Fourth Amendment rule. It can be hoped that it is only the rare case where the prosecutors act "vindictively." Nor would the prosecutor's testimony insisting that he was more concerned with "changing behavior" through "legal intervention" than with obtaining convictions and sentences alter the analysis. An interest in rehabilitation, rather than retribution, does not remove a prosecutors' actions from

the realm of "ordinary law enforcement." See Williams v. New York, 337 U.S. 241, 247-48 (1949).[2]

Finally, although it may be true that many of the arrests under the policy did not ripen into full-blown prosecutions – yet another basis advanced for distinguishing this policy from ordinary crime control efforts – that fact does not alter the policy's legal character. Even today, Defendants do not deny that they intended to prosecute those women who did not change their behavior to the prosecutor's satisfaction. Indeed, even if there was no intention to seek convictions, the need for Fourth Amendment protection would not recede: being arrested much less jailed on criminal charges should not be easily brushed aside under any circumstances, let alone those giving rise to this case. Individual Petitioners were subjected to degrading, non-medical, wholly unnecessary and even dangerous handling by the police. Various of them were shackled to their hospital beds, arrested shortly before or immediately after giving birth, often while still dressed in hospital gowns and still suffering pain and bleeding from the childbirth.

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[2] Although the panel majority concluded that the policy did not inflict punishment for its own sake, the evidence illustrates that the policy did seek to achieve another cardinal purpose of the criminal law: specific and general deterrence. Cf. Kennedy v. Mendoza-Martinez, 372 U.S. 144, 186 (1963) (describing deterrence as "an interest always thought to be furthered by the imposition of punishment for crime"). There was abundant testimony to that effect, and no policy other than deterrence could fully explain how arresting some of the patients after they gave birth served Defendants' professed purposes. Indeed, the Fourth Circuit majority itself stated, in upholding the policy against plaintiffs' privacy claim under the Due Process Clause, that "[i]t is well settled that a state has a compelling interest in the identification of law breakers and in deterring future misconduct." Ferguson v. City of Charleston, 186 F.3d 469, 483 (4th Cir. 1999), *cert. granted*, 120 S.Ct. 1239 (2000).

B. The Recruitment of Government-Paid Health Providers by Prosecutors Is Not Cause for Applying a Less Demanding Fourth Amendment Standard

The manifest constitutional unimportance of purportedly "benign" motives strongly suggests that the decision to apply the "special needs" standard was driven by the fact that many of the government actors in this case were medical personnel and that the searches were carried out by physicians and nurses, in a hospital setting. It is wrong to assume that the involvement of doctors requires less demanding Fourth Amendment review. To the contrary, when physicians and nurses are compelled to abandon their roles as protectors of and independent advocates for their patients' health interests and instead join forces with police and prosecutors, the dangers to freedom and well-being are heightened, not diminished. The need for vigilance may be even greater when the medical staff works for the state. See, e.g., Richard J. Bonnie & Svetlana Polubinskaya, Unraveling Soviet Psychiatry, 10 J. Contemp. Legal Issues 279 (1999); cf. Estelle v. Smith, 451 U.S. 454 (1981). The decision below cursorily assumed what it should have required Defendants to prove: that their policy was, in its design, and execution a genuinely "medical" one and that the patient protections inherent in the provision of medical care made full enforcement of Fourth Amendment safeguards unnecessary.

1. The Hospital Personnel Were Not Functioning As Medical Professionals

"The mere fact that a decision is made by a doctor does not make it 'certain that professional judgment was in fact exercised.'" Washington v. Harper, 494 U.S. 210, 253 (1990) (Stevens, J., concurring in part and dissenting in part) (quoting Youngberg v. Romeo, 457 U.S. 307, 321 (1982)). The record in this case makes clear that the policy required medical

personnel (1) to decide who among their patients would be subject to search and risk of prosecution; (2) to preserve the "chain of custody" of the urine samples taken from Petitioners and other patients, so that the samples could be probative evidence in a criminal proceeding; and (3) to track whether there was "legal grounds to arrest" the individual patients. Hildebrand Tr. 147, Joint Appendix (hereafter "JA") 617-619.

The policy's very nature and design required that physicians and nurses renounce their ethical responsibilities to patients and act in a manner that precludes any suggestion that they were rendering "medical treatment." The American Medical Association's Code of Medical Ethics requires physicians to act in the best interest of individual patients, to "deal honestly with patients", and to "safeguard patient confidences". AMERICAN MEDICAL ASS'N, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, E - PRINCIPLES OF MEDICAL ETHICS (Preamble). See also id. at §10.01. Physicians are also duty-bound to protect and foster patients' free, uncoerced choices in pursuing treatment, to treat patients equally, and to advocate on the patient's behalf. Id.

The policy respected none of these ethical instructions. Instead, it prompted care providers to be dishonest in their dealings with patients and to use explicit promises of non-disclosure as well as the trust inherent in their professional relationships to extract private and potentially inculpatory information. The policy failed to assure that the patients' consent to the urine screens was informed by the full range of relevant information. The policy short-circuited health providers' obligations to obtain suitable, individualized treatment for the patients who entrusted their care to them. Medical personnel were even compelled to turn patients over to police after they had given birth – behavior that was inconsistent with even the ostensible rationale for the policy – with no apparent regard for the health consequences of jailing

the mother of a newborn. Finally, with respect to the duty to treat patients equitably, the policy was confined to the overwhelmingly poor and disproportionately non-white group of patients seeking care at a public hospital. These indigent persons had few, if any, other health care providers to turn to. The policy required medical personnel to yield their independence of judgment and ally themselves with the interests of law enforcement officials rather than those of the patients who had come to the hospital seeking prenatal care they could not afford to purchase on the private market.

2. The Policy Contravened Basic Principles of Medical Practice

For nearly a century, the medical profession has understood that drug addiction is a disease, not simply the product of a failure of individual willpower. That understanding has received specific endorsement in the opinions of this Court. See Linder v. United States, 268 U.S. 5, 18 (1925) (explaining that drug dependent persons suffer from a disease and should be treated medically); Robinson v. California, 370 U.S. 660, 667 n.8 (1962) (stating that narcotic addiction is an illness which may be contracted "innocently or involuntarily"). See also Chasnoff Tr. 26-27, JA 294-96 ("the process of addiction is . . . not one of rational thought. It's not one of saying: if you keep using cocaine . . . or keep using alcohol here is what is going to happen to you. That doesn't work any better than saying if you keep smoking cigarettes you're going to die of lung cancer... It's a disease process that takes significant treatment and intervention in order to overcome.")

Like other diseases, drug dependency can be controlled and overcome through medical treatment, but for such treatment to be successful it must be informed by a rigorous understanding of the medical, psychiatric, and social dimensions of substance abuse, the interrelationship between

addiction and other medical problems, and the efficacy and limitations of various diagnostic instruments and various treatment approaches. See generally PRINCIPLES OF ADDICTION MEDICINE (Allan W. Graham, & Terry K. Schultz, eds. 2000). When, as here, the crafters of a policy aimed at combating substance abuse have no special training in treating substance abuse, it is incumbent upon them to recognize the limits of their expertise and not simply codify their uninformed hunches.

A starting point of any medical treatment of persons with substance abuse problems must be the recognition of the enormous extent of individual variation. See Chasnoff Tr. 27, JA 296 ("In a process of addiction treatment, [there] must be individualized treatment. You must consider all circumstances for the individual.") Many persons with addiction problems are dependent on more than one substance, and many have medical conditions that must be treated alongside their drug dependancy, such as trauma, depression, hepatitis, or HIV. In many cases, substance abuse is also aggravated by non-medical problems such as lack of adequate education, job skills, employment opportunities, familial support, public assistance and shelter. SHELLY GEHSHAN, A STEP TOWARD RECOVERY: IMPROVING ACCESS TO SUBSTANCE ABUSE TREATMENT FOR PREGNANT WOMEN, RESULTS FROM A REGIONAL STUDY (Southern Regional Project on Infant Mortality, 1993). Often the greatest favorable impact for an individual's substance abuse can be achieved by addressing these other aspects of the patient's condition.

For nearly three decades – and thus for many years before the policy at issue here was conceived – researchers have tracked the special treatment needs of pregnant, drug-dependent women, and many successful treatment programs (though not nearly enough to meet the need) are in operation across the country. Jessup Tr. 79, JA 710. Pregnant drug-dependent women suffer from depression at high rates and from low self-

esteem, and many experience intense guilt and sadness about the fetal health consequences of their substance abuse. In all cases, their decision to seek prenatal care is itself a highly positive step. And because such patients often lack the self-confidence that is important for completing treatment, it is particularly critical that they form a strong "therapeutic alliance" with those helping them.

Also, important differences have been found among the populations of men and women with substance abuse problems, indicating distinctive treatment approaches are often in order. For example, large numbers of drug-dependent women have been victims of sexual or other physical abuse, see, Jacqueline Wallen, A Comparison of Male and Female Clients in Substance Abuse Treatment, 9 J. Subst Abuse Treat 243 (1992), and women with substance abuse problems are far more likely than their male counterparts to have childcare responsibilities. See Chasnoff Tr. 31, JA 296 (contrasting substance-dependent men, who say, "I have got to get into treatment, where do I go," with women who often say "okay, I'm ready for treatment . . . .what do I do with my kid"); Ferguson Tr. 194, JA 470 ("I had two kids at home. Six weeks is a long time if you don't have someone to take care of your kids"). For women with children, studies have shown that treatment outcomes improve substantially when treatment programs take into account patients' needs for transportation to appointments, job training, primary medical care, education, child care, and medical care for infants and children. Margaret E. Goldberg, Substance-abusing Women: False Stereotypes and Real Needs, 40 Social Work 789 (1995).

The search and arrest policy at issue here did not proceed from sound premises. Those involved in its development had no relevant expertise and made scant effort to consult those who were knowledgeable. See Haynes Tr. 64, JA 601-02 (failing to seek input from Director of the Office of

Women's Services for SC Commission on Alcohol and Drug Abuse). Indeed, the one prominent expert they did contact expressly urged Defendants not to pursue the policy, Chasnoff Tr. 24, JA 294, warning that the arrest policy would "in fact drive women out the treatment programs and out of prenatal care," id., and that "just focusing on cocaine" would not "move[] [Charleston] toward . . . the stated outcome, improving the health of the child." Chasnoff Tr. 14, JA 283.

Before acting, Defendants made no effort to substantiate their sense that cocaine exposure among neonates was on the increase or, for that matter, that such children were, in fact, suffering health problems distinct from other children born to the hospital's impoverished patient population. The screening criteria used to decide which women risked arrest and criminal liability were entirely unscientific. Indeed, the hospital never conducted universal drug testing of pregnant women or newborns. Thus, Defendants had no way of knowing whether there was any actual increase in cocaine use by pregnant patients, whether there was any increase in health problems that could be associated in newborns, or whether the testing criteria were effective in identifying cocaine users.[3]

Furthermore, Defendants had no evidence on which to base their belief that the arrest policy would have its hoped for deterrent effect. In fact, the policy was continued despite the absence of studies demonstrating the efficacy of arresting pregnant women and a growing body of research predating the policy's implementation that threat-based approaches do not work. See PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS 79 (Inst. of Medicine ed., 1988) ("Pregnant [substance

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[3] It should also be noted that testing – and prosecuting – only females raises serious concerns, in light of evidence that paternal exposure to teratogens can pose health risks to fetuses. Cf. United Auto Workers v. Johnson Controls, 499 U.S. 187 (1991).

abusers] in particular may delay care . . . because they fear that if their use of drugs is uncovered, they will be arrested . . . ."). See also Marilyn C. Poland, Punishing Pregnant Drug Users: Enhancing the Flight from Care, 31 Drug & Alcohol Dependence 199 (1993); U.S. DEPT OF HEALTH AND HUMAN SERVICES, CENTER FOR SUBSTANCE ABUSE TREATMENT, PREGNANT, SUBSTANCE-USING WOMEN, TREATMENT IMPROVEMENT PROTOCOLS SERIES NO. 2 (1993). Indeed, public health organizations and government agencies, treatment professionals and scientific researchers resoundingly repudiated punitive strategies.

When MUSC's own resident bioethicist later reviewed the policy, she concluded that "no evidence suggests that this particular policy promoted healthy pregnancies or reduced costs, instead the policy alienated a patient population. . . ." Mary Faith Marshall et al., Letters to the Editor, 23 J. of Law, Med. & Ethics 299-300 (1995). See also, Philip H. Jos et al., The Charleston Policy on Cocaine Use During Pregnancy: A Cautionary Tale, 23 J. of Law, Med. & Ethics 120 (1995).

Even when a therapeutic component was belatedly added, no attempt was made to adapt the "treatment" to the patients' individualized medical needs. Instead, all patients were referred to the same program, one developed by individuals with no experience or expertise in treating pregnant women. Beckett Tr. 237-238, JA 57 (program operators "learned through the process of working with the clients exactly what we were up against").

II. The Policy's "Benefits" Did Not Justify Its Burdens on Petitioners' Privacy

Although the decision below was wrong to treat the policy as entitled to consideration under the standards established in this Court's "special needs" decisions, that error might well have been harmless had the appeals court fairly applied those cases' teachings in considering constitutional

"reasonableness." Instead, the panel majority fixed on the importance of the policy's stated aim and slighted or ignored entirely the extent of its affront to personal privacy, the important ways that it did not (and, by design, could not have) met its objectives, and the manner by which it caused hard-to-repair damage to public health and medical practice.

A. The Policy Harmed the Relationship Between Treatment Providers and Patients

The fundamental error infecting both the policy and the judicial decision approving it is the failure to respect the importance of the therapeutic relationship between patients and their treatment providers. Although, as discussed above, the obligations of loyalty, confidentiality, and candor that characterize that relationship are ethical and fiduciary imperatives, they also serve a critical, practical purpose in the effective delivery of health care. As this Court recognized in Jaffe v. Redmond, 518 U.S. 1 (1997), confidentiality and trust are not solely matters of principle: "the mere possibility of disclosure [of patients' confidences] may impede development of the . . . relationship necessary for successful treatment." Id. at 10.

> To make diagnoses and treat patients effectively, the physician must obtain sensitive information about a patient. A patient must be willing to tell a physician, who is often a total stranger, about such matters as drug usage . . . and to allow the physician to examine intimate parts of his or her anatomy. The promise of confidentiality encourages patients to disclose sensitive subjects to a physician without fear that an embarrassing condition will be revealed to unauthorized people . . . .

Robert Arnold, et al., Medical Ethics and Doctor/Patient Communication, in THE MEDICAL INTERVIEW: CLINICAL CARE, EDUCATION AND RESEARCH 345, 365 (Mack Lipkin, Jr., et al.

eds., 1995); Aaron Lazare, Shame, Humiliation, and Stigma in the Medical Interview, in id. at 333.

Defendants' policy played upon and misleadingly fostered patients' well-founded assumption that their relationship with their health care providers was one of trust. Such assumptions, however, are fragile and cannot long survive breaches of confidentiality of the sort involved here. Even the possibility that treatment professionals will share personal medical records and test results with police – let alone that they might perform such tests with the purpose of obtaining incriminating evidence – does lasting harm to the relationships necessary for medical care and is injurious to the broader public health.

The prospect that confidentiality might be breached (with potentially harsh penal consequences) effects patient care in another important way. Not only are persons needing treatment deterred from seeking medical care, but those who do see physicians and nurses are less likely to provide the sort of candid disclosure that is often vital for effective medical treatment.

Unsurprisingly, what is true about patients generally, applies with particular force to those with substance abuse problems:

> It is quite clear that part of treating [a chemically dependent person] as a patient includes embracing all of the appropriate ethical constraints of health care delivery . . . . Possibly at the top of the list of ethical issues that are of very special and fundamental importance to this group of patients is the appropriate maintenance of confidentiality.

Mary Jeanne Kreek & Marc Reisinger, The Addict as a Patient, in SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK 822, 826-27 (Joyce H. Lowinson, et al. eds., 1997). Cf. 42 U.S.C. § 290dd-2 (prohibiting federally assisted drug-abuse treatment

programs from divulging patient identities and records); id. at § 9501(1)(H) (codifying patients' "right to confidentiality" of mental health records).

This is even more urgently the case when drug-dependent patients are pregnant. Such patients are particularly reticent to see physicians, and are especially reluctant to give accurate information concerning the nature and extent of their drug use. See SOUTHERN REGIONAL PROJECT ON INFANT MORTALITY, A STEP TOWARD RECOVERY: IMPROVING ACCESS TO SUBSTANCE ABUSE TREATMENT FOR PREGNANT AND PARENTING WOMEN 21 (1993). See also UNITED STATES GENERAL ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, SENATE COMM. ON FINANCE, HRD-90-138, at 9-10 (1990) ([S]ome drug-using women are now delivering their infants at home in order to prevent being reported to . . . authorities"). Indeed, research has found that the Charleston policy itself had this effect. See L.G. Tribble et al., Analysis of a Hospital Maternal Cocaine Testing Policy: In Association with Prenatal Care Utilization Patterns (Nat'l Perinatal Ass'n 1993).

B. Erosion of the Treatment Provider-Patient Relationship Undermines the Health of Women and Children

Reluctance to seek medical treatment or confide fully in those providing such treatment can have serious adverse health consequences for pregnant women and their fetuses – the very health interests the policy purported to advance. Open communication with treatment providers regarding drug use is necessary to ensure optimum safety before, during and after deliveries. See David J. Birnbach et al., Cocaine Screening of Parturients Without Prenatal Care: An Evaluation of a Rapid Screening Assay, 84 Anesthesia Analg. 76 (1997) (patients using cocaine "may have untoward responses to anesthesia"); D. Campbell et al., Unrecognized "Crack" Cocaine Abuse in Pregnancy, 77 British J. Anaesthesiology 553, 555 (1996)

(eliciting concrete information about drug use is important because the "interaction of cocaine with other local anaesthetics makes the calculation of a safe maximum dose difficult").

By contrast, when substance abuse, including cocaine use, is known to care givers, they can focus on providing a number of proven interventions that substantially increase the health outcomes for children after delivery. One of the most effective weapons against infant mortality is early, high-quality, comprehensive prenatal care. See, e.g., SOUTHERN REGIONAL PROJECT ON INFANT MORTALITY, A STEP TOWARD RECOVERY: IMPROVING ACCESS TO SUBSTANCE ABUSE TREATMENT FOR PREGNANT AND PARENTING WOMEN 6 (1993). Indeed, prenatal care has been shown to markedly improve pregnancy outcomes among women with addictions: pregnant women who use cocaine, among other substances, but who have at least four prenatal care visits have been found to significantly reduce their chances of delivering low birth weight babies. Andrew Racine et al., The Ass'n Between Prenatal Care and Birth Weight Among Women Exposed to Cocaine in New York City, 270 JAMA 1581, 1585-86 (1993).

Even if the pregnant patient does not reduce or discontinue drug use, health risks associated with prenatal drug exposure can be mitigated substantially through prenatal care and counseling if the patient embraces the therapeutic relationship. Id. Adequate parenting skills and a supportive environment also appear to help lessen the risk of serious harm. See, e.g., Loretta P. Finnegan & Stephen R. Kandall, Maternal and Neonatal Effects of Alcohol and Drugs in SUBSTANCE ABUSE: A COMPREHENSIVE HANDBOOK, supra at 529. In short, a climate of confidentiality is essential if patients are to disclose drug-use and/or seek continued care and counseling from health professionals in order to reduce the potential harms caused by substance use during pregnancy.

This accumulation of clinical evidence as to the special barriers to, and special benefits of full disclosure by pregnant women with substance abuse problems has led those who have studied this issue to conclude, with an unusual degree of unanimity, that punitive approaches such as the one here are not merely ineffective, they are counterproductive. In fact, *Amici* and every other prominent public health and medical organization to have given the subject serious consideration have rejected the notion of turning to the criminal justice system to address drug use during pregnancy. See, e.g., National Council on Alcoholism and Drug Dependence, WOMEN, ALCOHOL, OTHER DRUGS AND PREGNANCY (1990) ("[A] punitive approach is fundamentally unfair to women suffering from addictive diseases and serves to drive them away from seeking both prenatal care and treatment for their alcoholism and other drug addictions. It thus works against the best interests of infants and children . . . ."); AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS ("ACOG"), COMMITTEE OPINION 55 (Oct. 1987) (resorting to courts "is almost never justified" in treating pregnant women); American Academy of Pediatrics, Comm. on Substance Abuse, Drug-Exposed Infants, 86 Pediatrics 639, 642 (1990) ("The public must be assured of nonpunitive access to comprehensive care which will meet the needs of the substance-abusing pregnant woman and her infant."); AMERICAN NURSES ASS'N, POSITION STATEMENT (Apr. 5, 1992) (opposing "any legislation that focuses on the criminal punishment of the mothers of drug-exposed infants . . . . The threat of criminal prosecution is counterproductive in that it prevents many women from seeking prenatal care and treatment for their alcohol and other drug problems.") See generally, State v. Luster, 419 S.E. 2d 32, 35 n.2 (Ga. 1992) (listing medical and public health organizations opposing the prosecution of women for cocaine use during pregnancy).

C. The Policy Cannot Be Called "Effective" For Fourth Amendment Purposes

The decision below did not advert to this remarkable scientific and professional consensus that police-centered and prosecution-based approaches cause more harm than good for the children exposed to drugs *in utero*. The panel majority ignored the evidence that the policy was fundamentally misguided and could not have worked, as well as reports that the policy, in practice, failed to achieve its intended effect. Rather, the Fourth Circuit majority summarily pronounced the policy "an effective way to identify and treat maternal cocaine use," going so far as to characterize it as the "only effective means available . . . to reduce health effects on children exposed to cocaine *in utero*." Ferguson, 186 F.3d at 478 (emphasis added). No support for this bold assertion appears in the decision. Indeed, there could be none. Instead, the panel majority essentially held that substantial privacy invasions pass constitutional muster irrespective of whether the policy actually achieved its purported goal.

Although the decision correctly cited this Court's opinion in Michigan Dep't of State Police v. Sitz, 496 U.S. 444 (1990) for the proposition that the Fourth Amendment imposes no obligation on government actors to implement the most effective policy, that decision gave no license to disregard evidence that a policy has effects directly contrary to its purpose. Cf. Chandler v. Miller, 520 U.S. 305, 306 (1997) (policy was not "well designed" to catch lawbreakers and was not a "credible deterrent").

Unlike in Sitz, where claims of ineffectiveness were largely predicated on the low percentage (in absolute terms) of drunk drivers detected, Sitz, 496 U.S. at 445 (distinguishing Delaware v. Prouse, 440 U.S. 648 (1979)), this case involved the singling out of particular individuals for a far more momentous invasion of privacy. Moreover, in cases such as

Sitz, which involved stopping motorists and checking for intoxication, deterrence plays an important and unambiguously positive role in the policy's efficacy: the desire not to be apprehended can lead drivers either not to become inebriated in the first place or make those who do become inebriated more likely to stay home. But here, the consequences of drug-dependent pregnant women's "staying home," *i.e.*, not seeking prenatal care, are calamitous for both mother and fetus, as are the costs of evading detection through dishonesty to a treating physician.[4]

Despite its sweeping pronouncements concerning the policy's effectiveness, the decision below evaded the panel's acknowledged responsibility to evaluate the "effectiveness of the policy . . ." Ferguson, 186 F.3d at 477. Instead, the panel majority's consideration of the issue took a surprising turn, insisting that the court's responsibility was confined to deciding whether the process of urinalysis is "effective." Id. at 478 n.8.

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[4] At least two other distinctions warrant mention. First, although *Amici* are deeply concerned about alcohol-dependency as a disease, it remains true that a substantial portion of those who engage in driving while intoxicated are not alcohol-dependent, and even those who suffer from the disease of alcoholism are not required by law to refrain from either drinking or driving, only from doing both at the same time. There is no dispute that the targets of Charleston policy were exclusively or nearly exclusively pregnant drug-dependent women, and that the nature of drug dependency during pregnancy leaves no room for any similar accommodation. Cf. Johnson v. State, 602 So. 2d 1288, 1294 (1992) ("a woman may abort her child or avoid prenatal care or treatment out of fear of prosecution.") See also People v. Hardy, 469 N.W. 2d 50 (1999). Second, it bears mention that, despite the documented threat to human life posed by intoxicated driving, the sentences for first-time offenders are far less stiff than those which Petitioners confronted. See S.C. CODE ANN. §56-5-2940 (Law. Co-op. 1999) (imposing a fine of $300 or imprisonment of not less than 48 hours and no more than 30 days for first offense).

Although *Amici* do not question that urine screens, when properly conducted, can yield evidence of prior exposure to drugs, it cannot be said that urinalysis itself is a way to "treat" substance use generally, or maternal drug use specifically. Knowing that a policy relies on urine testing says nothing abut whether patients are provided with effective treatment: urine screen results could be thrown away; they could be used for medical research purposes only; they could be used for voluntary counseling of patients, or for a more aggressive medical approach; or, as here, they could be used as the principal part of a policy predicated on "legal intervention." It is also patently absurd to place the same diagnostic label of "addiction" on individuals whose only commonality is a single toxicological result, which even if accurate, cannot distinguish between the first-time-ever user and the chronic user, let alone between the long-term intermittent "chipper" and the individual whose drug dependence is such as to require several dosages each and every day. See AMERICAN MEDICAL ASS'N POLICY H-95.985 ("Drug testing does not provide any information about pattern of use of drugs, abuse of or dependence on drugs, or about mental or physical impairments that may result from drug use."). The correct and legitimate question is whether the policy pursuant to which the samples were taken was sufficiently effective to justify the search, and on that point the evidence is unambiguous: Defendants' policy did not work.

Similarly, although the panel majority's assertion that urine screens are "effective at identifying" instances of fetal cocaine exposure appears at first blush to be a statement of unexceptionable fact, it, too, obscures the relevant medical and Fourth Amendment questions. As noted previously, the bases for selecting patients for screening were wholly unscientific and subjective in their application, raising serious questions as to whether testing was applied even-handedly among MUSC patients who were similarly situated. What is more, the policy assured that the many other women in Charleston who met

precisely the same "criteria" as did Petitioners – but who were not MUSC patients – were not searched at all.

Incredibly, the decision below held that these considerations did not "bear on" the Fourth Amendment inquiry. That holding is plain error. The constitutional right that Petitioners asserted is the right to be free of "unreasonable searches." The general rule, of course, is that searches not based on individualized determinations of probable cause are unreasonable *per se*, but there is no basis for suggesting that in the "narrow" class of cases where the *per se* rule properly does not govern, the dangers of arbitrary or uneven enforcement against which the probable cause requirement protects no longer "bear on" the Fourth Amendment validity of governmental action. Indeed, the Court's opinion in Sitz definitively contradicts any such assertion.

D. "Medical" Urine Screens Entail A Substantial Privacy Intrusion

Just as it gave short shrift to the "effective advancement of the public interest" side of the balance, the decision below slighted the personal privacy rights implicated by the policy. Indeed, much as it relied on the medical setting to find a "special need" in the first place, the majority opinion cited "the context in which the searches at issue here occurred" to support its conclusion that the urine testing in this case did not deserve the full privacy protections afforded by the Fourth Amendment. Ferguson, 186 F.3d at 479. Because "the collection and testing of urine was conducted in the course of medical treatment to which [Petitioners] had consented," the Fourth Circuit explained, and "giving of a urine sample is a normal, routine, and expected part of a medical examination," the court held the privacy invasion only "minimally intrusive." Id.

This explanation ignores precisely what it is that enables physicians and counselors "routine[ly]" to perform intimate tests and elicit medically necessary but embarrassing or

incriminating personal information: the informed consent of the patient, obtained with both explicit and implicit reference to the duties of care and confidentiality. See Jaffe v. Redmond, 518 U.S. 1, 12 (1997) (noting that in absence of therapist-patient privilege, "evidence" sought from therapist's notes would never have come into being).

There is a fundamental difference between a patient's allowing a single doctor or nurse to perform an examination or conduct a test in connection with medical treatment, and having the same procedure conducted or observed, or test results known, by police, prosecutors, and a multitude of others. That difference is not merely intuitive. It has medical and constitutional significance. The identities of those who will have access to test results and the purposes to which those results will be put is "material" information that must be disclosed in order to obtain informed consent. Cf. Wilson v. Layne, 526 U.S. 603 (1999) (finding a constitutionally impermissible intrusion on privacy when a government official, though present in a home pursuant to a valid warrant, is accompanied by members of the press or public).

III. Cocaine Use Among Pregnant Women Does Not Present a "Special Need"

A consistent theme of cases exempting governmental actors from the warrant requirements is that the Fourth Amendment must not be construed as preventing the government from responding "reasonably" to exigent circumstances and crises — a strain that is evident in certain "special needs" cases. See Skinner v. Railway Labor Execs. Ass'n, 489 U.S. 602 (1989); Vernonia Sch Dist. 47J v. Acton, 515 U.S. 646 (1995). In these cases, however, the limitation "beyond those of ordinary law enforcement" has a different connotation: the problems were so formidable that the Fourth Amendment restraint should not apply. The behavior of the Defendants and, to a lesser extent, the opinion of the Fourth

Circuit majority proceed on the assumption that cocaine use by pregnant women presented such a crisis, both because more conventional medical and law enforcement measures had failed to stem the problem and because most of the health hazards risks were different in kind from those with which law enforcement (or the medical profession) usually deal.

Neither of these suppositions is correct. First, it is patently clear that no medically appropriate drug treatment policy had been tried and failed for women, such as Petitioners, who were drug-dependent and pregnant. See, e.g., Horger Tr. 19-20, JA 643-44.

As for Defendant's assumption of cocaine's unique danger when ingested during pregnancy, although that understanding is consistent with the sensationalistic media accounts of the time, it is without support from empirical data.[5]

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[5] See Albert J. Tuboku-Metzger et al., Cardiovascular Effects of Cocaine in Neonates Exposed Prenatally, 13 American J. of Perinatology 1 (1996) (study of chronic cocaine use among pregnant subjects finding no direct effects on the health or development of newborns); Bertis B. Little et al., Is There a Cocaine Syndrome? Dysmorphic and Anthropometric Assessment of Infants Exposed to Cocaine, 54 Teratology 145 (1996) (finding no recognizable constellation of dysmorphic features to distinguish between cocaine-exposed and non-exposed infants); Nancy Stewart Woods et al., Cocaine Use During Pregnancy: Maternal Depressive Symptoms and Infant Neurobehavior over the First Month, 16 Infant Behavior and Dev. 83, 92 (1993) (finding no differences in neurobehavioral performance of cocaine-exposed infants when compared to non-exposed infants); Claire D. Coles et al., Effects of Cocaine and Alcohol Use in Pregnancy on Neonatal Growth and Neurobehavioral Status, 14 Neurotoxicology and Teratology 23, 31-32 (1992) (finding prenatal cocaine exposure effects fetal growth but that cocaine-exposed infants do not appear otherwise impaired physically or behaviorally in the neonatal period); Barry M. Lester et al., Data Base of Studies of Prenatal Cocaine Exposure and Child Outcome, 27 J. of Drug Issues 487 (1997) (concluding that knowledge about the existence or extent of effects of prenatal cocaine exposure on child outcome is limited, scattered, and compromised by methodological shortcomings); Ellen

In so noting, *Amici* do not condone the use of illegal drugs. Furthermore, *Amici* in no way wish to downplay the harm that ingesting any substance could cause to a fetus or child. Indeed, *Amici* share a professional dedication to avoiding and reducing any such dangers. Nonetheless, it is important that this Court not labor under the same misperception as did the Defendants.

The policy at issue was predicated on the unproven assumption that prenatal exposure to cocaine causes long-term, deleterious effects on child development different in scope, degree and kind from risks posed by maternal behavior or exposure to other substances, licit or illicit. In fact, studies have not validated such an assumption. Not long after the Charleston policy was implemented, an article in the Journal of the American Medical Association reported that:

> review of the current literature on the subject [of the adverse effects in infants born to cocaine-using mothers] indicates that available evidence from the newborn period is far too slim and fragmented to allow any clear predictions about the effects of intrauterine exposure to cocaine on the course and outcome of child grown and development. . . . Findings about neurobehavioral effects in the newborn period have been inconsistent or contradictory. Significantly, no prospective study of unique long-term consequences of intrauterine cocaine, non-opiate exposure has been published in the peer-review literature.

Hutchins, Drug Use During Pregnancy, 27 J. of Drug Issues 463, 466 (1997). See also LAURA E. GOMEZ, MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS, AND THE POLITICS OF PRENATAL DRUG EXPOSURE 23-25 (1997) (discussing the failure of longitudinal studies to find statistically significant differences between cocaine-exposed children and non-exposed children).

Linda C. Mayes et al., The Problem of Prenatal Cocaine Exposure: A Rush to Judgment, 267 JAMA 406 (1992) (internal citations omitted).[6]

A standard pediatrics textbook published the following year reaches the same conclusion, observing that "[t]o date no hypothesized or demonstrated effect of *in utero* cocaine exposure has been found to be specific to that drug. No studies have shown that prenatal cocaine exposure causes unique developmental dysfunction." Deborah A. Frank et al., Maternal Cocaine Use: Impact on Child Health and Development, 40 Advances in Pediatrics 65, 92 (1993). See also Gail A. Wasserman et al., Prenatal Cocaine Exposure and School Age Intelligence, 50 Drug & Alcohol Dependence 203, 209 (1998) ("prenatal cocaine exposure does not seem to confer an additional risk for adverse developmental outcome"); Hallam Hurt et al., Children with *In Utero* Cocaine Exposure Do Not Differ from Control Subjects On Intelligence Testing, 151 Arch. Ped. Adolesc. Med. 1237 (1997).

In the end, Defendants' purported good intentions carried the day in the court below. However, as a result of these intentions, medical professionals were compelled to ignore the ethical mandates of their discipline, the core teachings of their clinical experience, and the scientific data of peer reviewed research. This Court should not countenance the Charleston policy's unreasonable, counterproductive and wholly unnecessary assault on the professional autonomy of treatment providers, the medical privacy of patients, and the furtherance of public health.

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[6] According to a publication of the Harvard Medical School, two years after the Charleston policy was implemented a "combined analysis of 20 studies on cocaine and pregnancy found few effects that could be specifically attributed to cocaine." Update on Cocaine: Part I, 10 Harv. Mental Health Letter (Harv. Med. Sch.), Aug. 1993, at 3.

Conclusion

It has been and remains a principal object of judicial enforcement of the Fourth Amendment to distinguish between those cases where otherwise unconstitutional law enforcement tactics are truly necessary and those where the claims of "crisis" – even if sincerely subscribed to by "men of zeal" – turn out to be illusory. The Charleston policy falls squarely into the latter category. As explained above, the ongoing effects of the Fourth Circuit's approval of that policy continue to compromise the effective delivery of health care. Accordingly, this Court should reverse the decision of the panel majority below.

Respectfully submitted,

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APPENDIX

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Amicus Curiae American Public Health Association ("APHA") is a national organization devoted to the promotion and protection of personal and environmental health. Founded in 1872, APHA is the largest public health organization in the world, representing over 50,000 public health professionals. It represents all disciplines and specialties in public health, including maternal and child health and substance abuse. APHA strives to improve public health for everyone by proposing solutions based on research, helping to set public health practice standards, and working closely with national and international health agencies.

Amicus Curiae South Carolina Medical Association ("SCMA") is the primary professional association for individuals licensed to practice medicine in South Carolina. SCMA has over 5,500 members representing all medical specialties that provide medical services to the citizens of the state. SCMA's primary mission is to foster high ethical and clinical standards for the practice of medicine in South Carolina. To this end, SCMA opposes policies and practices that undermine patient confidentiality and weaken the trust between health care providers and patients that promotes positive treatment outcomes.

Amicus Curiae American College of Obstetricians and Gynecologists ("ACOG"), founded in 1951, is a private, voluntary, not-for-profit organization of physicians who specialize in obstetric and gynecologic care. The leading group of professionals providing health care to women, ACOG's more than 38,000 members represent over 90 percent of all obstetricians and gynecologists currently practicing in the United

States. ACOG is dedicated to educating health care professionals, law and policy makers and the general public about women's health care. ACOG is further devoted to assuring that all women have access to prenatal care for the benefit of both the fetus and the mother. Accordingly, ACOG opposes policies, like that implemented by Charleston, that deter substance dependent women from seeking prenatal care.

Amicus Curiae American Nurses Association ("ANA") is a professional organization representing this nation's over 2.2 million registered nurses. ANA is committed to ensuring the availability and accessibility of health care services. It believes that access to maternal-child health services is particularly critical to efforts to prevent disease and to provide early intervention for health care problems. Thus, it opposes all barriers to prenatal care. ANA is concerned that when health care providers divulge patient information to law enforcement officials, women in need of prenatal care and/or substance abuse treatment are deterred from seeking these essential services.

Amicus Curiae National Association of Alcoholism and Drug Abuse Counselors, Inc. ("NAADAC") is the nation's largest organization of alcohol and drug counselors, with 17,000 members. NAADAC's members have special expertise in the substance abuse treatment needs of pregnant women. NAADAC joins this brief because it is deeply concerned that the decision below, if permitted to stand, will undermine the quality of care that South Carolina substance abuse professionals can provide pregnant patients, and will deter pregnant women from seeking these essential services.

Amicus Curiae National Association of Social Workers, Inc. ("NASW") is the world's largest association of professional social workers with over 155,000 members in fifty-five chapters throughout the United States and abroad. Founded in 1955,

NASW is devoted to promoting the quality and effectiveness of social work practice, advancing the knowledge base of the social work profession, and improving the quality of life through utilization of social work knowledge and skills. The South Carolina chapter of NASW has over 1,260 members. NASW and its South Carolina chapter believe that the expansion of law enforcement into the treatment context and the blurring of lines between prenatal/obstetrical care providers and peace officers is inimical to family stability and counter to the best interests of the child.

Amicus Curiae Society of General Internal Medicine ("SGIM") is the professional society of academic physicians who teach and conduct research in primary care Internal Medicine. The Society, which has nearly 3,000 members in the United States (including South Carolina) and 11 other countries, publishes the Journal of General Internal Medicine and is a leader in research and education in the medical care of adults. Many SGIM members have national expertise in issues related to alcoholism and abuse of other substances. SGIM is deeply concerned that the Ferguson decision, if let stand, could deter women in South Carolina and elsewhere from seeking drug-treatment and prenatal services that are essential to the delivery of a healthy child. The failure to maintain proper patient confidentiality (at the heart of MUSC's policy) will not only discourage women from seeking this vital care but will interfere with physicians' ability to provide it when sought.

Amicus Curiae National Council on Alcoholism and Drug Dependence ("NCADD") with its nationwide network of affiliates, provides education, information, and hope in the fight against the chronic diseases of alcoholism and other drug addictions. Founded in 1944, NCADD historically has provided confidential assessment and referral services for alcoholics and other drug addicts seeking treatment. If NCADD affiliates were

required to provide the names and medical information of drug-using pregnant women to law enforcement authorities, it would greatly inhibit their ability to serve this population. In 1990, the NCADD Board of Directors adopted a policy statement on "Women, Alcohol, Other Drugs and Pregnancy" recommending that "[s]tates should avoid measures which would define alcohol and other drug use during pregnancy as prenatal child abuse and should avoid prosecutions, jailing or other punitive measures which would serve to discourage women from seeking health care services."

Amicus Curiae American Society of Addiction Medicine ("ASAM") is devoted to increasing access to and improving the quality of addiction treatment. ASAM members are physicians from all medical specialties and sub-specialties. They are engaged in private practice, serve as corporate medical directors, work in group practice or other clinical settings, and are also involved in research and education. Through its conferences, continuing medical education courses, and publications, including the quarterly Journal of Addictive Diseases, ASAM actively educates the medical community and the public about addiction disorders and diseases, treatment guidelines and practice parameters in the field of addiction medicine. ASAM staunchly opposes policies that create obstacles to or deter persons from receiving substance abuse treatment and counseling.

Amicus Curiae National Medical Association ("NMA"), established in 1895, is the nation's largest and oldest professional, educational and scientific organization representing the interests of more than 25,000 African American physicians and their patients, as well as more than 100 state and local societies. As the leading force for parity and justice in medicine and the catalyst for the elimination of disparities in health, NMA is committed to improving the health status and outcomes of

minorities and the poor. While NMA has historically focused on health issues related to African American and medically underserved populations, its principles, goals, initiatives and philosophy address and benefit all Americans. To these ends, NMA opposes the Charleston policy because it is counterproductive to public health and infected by the taint of racial and gender bias.

Amicus Curiae American Academy of Addiction Psychiatry ("AAAP") is an international professional membership organization founded in 1985 with approximately 1,000 members in the United States and around the world. The membership consists of psychiatrists who work with addiction in their practices, faculty at various academic institutions, non-psychiatrist professionals who are making a contribution to the field of addiction psychiatry, residents and medical students.

Amicus Curiae South Carolina Nurses Association ("SCNA") is a professional organization which represents registered nurses in South Carolina. SCNA strongly supports health care for a number of vulnerable populations, and believes patients must be secure in the knowledge that their treatment providers are wholly devoted to treatment and are not doubling as the agents of law enforcement. In 1991, SCNA issued a position statement opposing the criminal prosecution of women for drug use while pregnant. SCNA continues to believe that the breaching of patient confidentiality and the threat of criminal prosecution deters pregnant women who suffer from chemical dependence from seeking and obtaining prenatal care.

Amicus Curiae Association for Medical Education and Research in Substance Abuse ("AMERSA") is a national organization of three hundred health care and social services professionals. AMERSA is committed to educating physicians, nurses, social workers, and other health care and social services

professionals on the recognition and treatment of alcohol and drug problems. Many of AMERSA's members are psychiatrists, nurses, and social workers who specialize in substance abuse treatment; others are internists, family physicians, pediatricians, nurses, and social workers who work in general health and social services settings identifying and assisting individuals with alcohol and drug problems; most members are professors at medical schools, nursing schools, or social work programs. To be effective, prenatal care and treatment for pregnant addicts must occur in the context of a confidential, respectful, and trusting relationship between professional and patient. When this relationship is jeopardized net harm to the health of mothers and children will likely occur because women will be deterred from obtaining prenatal care, addiction treatment, and counseling.

Amicus Curiae Physicians for Human Rights ("PHR") is an organization of health professionals, scientists, and concerned citizens that uses the medical and forensic sciences to investigate violations of human rights. PHR is at the forefront of integrating human rights and bioethics, and in 1997 shared the Nobel Peace Prize for its epidemiological investigations of landmines and founding role in the International Campaign to Ban Landmines. A coauthor of *Human Rights and Health: The Legacy of Apartheid*, PHR is committed to exposing the harms that result when the State coerces health workers to abandon their professional training and ethical obligations in order to advance political ends.

Amicus Curiae American Medical Women's Association ("AMWA") is a national, non-profit organization of over 10,000 women physicians and physicians-in-training representing every medical specialty. Founded in 1915, AMWA is dedicated to promoting women in medicine and advocating for improved women's health policy. AMWA strongly supports treatment and

rehabilitation of women who use alcohol and drugs during pregnancy, and opposes the arrest, jailing and/or prosecution of pregnant women as a method for preventing or punishing chemical dependency during pregnancy. AMWA encourages all pregnant women to seek prenatal care and believes that breaching the medical confidentiality of these women or otherwise hindering their ability to establish a relationship of trust with their treatment providers will deter women, especially those that may be at high risk for adverse pregnancy outcomes, from receiving prenatal care.

Amicus Curiae Association of Reproductive Health Professionals ("ARHP") is a non-profit, interdisciplinary medical association for leaders in the field of reproductive health. Founded in 1963 and comprised of physicians, nurse practitioners, other clinicians, pharmacists, and researchers, ARHP serves as an important source of reproductive health education and information for health care professionals, patients, the media, legislators, and other professionals. ARHP is deeply concerned that the Charleston policy threatens to undermine the quality of care provided by physicians, nurse practitioners, and other clinicians who treat pregnant and parenting women in South Carolina.

Amicus Curiae Planned Parenthood Federation of America, Inc. ("PPFA"), a New York not-for-profit corporation, is the world's oldest and largest voluntary reproductive health care organization. PPFA provides leadership to 132 autonomous affiliates that manage 900 health centers in 47 states and the District of Columbia that provide education and medical services to nearly five million women and men a year. PPFA and its affiliates are committed to providing confidential medical services in an effort to provide a safe environment where patients are comfortable making important decisions about their reproductive and related health care needs. Thus, PPFA is

profoundly concerned about the Charleston policy at issue and it's impact on the confidential nature of the doctor-patent relationship and related public health issues.

Amicus Curiae Society for Medical Anthropology ("SMA") is a private, voluntary, not-for-profit organization of anthropologists and other social scientists specializing in the anthropological study of health and healing. SMA supports its members in the goal of educating academic and lay audiences about the cultural dimensions of health and disease in order to improve the health of all populations. SMA is concerned about any policy or practice that may prevent persons from seeking medical care during pregnancy. Prenatal care – which includes open and trusting communication between women and their care givers – is vital to positive birth outcomes, especially for low-income women whose poverty increases the risk of adverse health consequences.

Amicus Curiae California Medical Association ("CMA") is the primary professional association for individuals licensed to practice medicine in California. As the largest state medical association in the U.S., CMA has over more than 30,000 members representing all medical specialties that provide medical services throughout the state. CMA's primary mission is to foster high ethical and clinical standards for the practice of medicine in California. CMA thus stands opposed to laws and policies, like the policy being challenged here, that unnecessarily hinder the effective practice of medicine or that have the effect of depriving persons of needed medical care.

Amicus Curiae California Society of Addiction Medicine ("CSAM") is the California chapter of The American Society of Addiction Medicine. CSAM's mission is to increase access to and improve the quality of addiction treatment through education and research, and to reduce the stigma and prejudice

commonly associated with addiction disorders. Accordingly, CSAM opposes the policy being challenged in this case as it has the effect of driving pregnant women away from substance abuse treatment and further stigmatizing chemical dependence by entwining it with criminal justice ramifications.

Amicus Curiae Robert E. Arendt, Ph.D., is an Assistant Professor in the Department of Pediatrics, School of Medicine at Case Western Reserve University. He is the principal investigator on a longitudinal study funded by the National Institute of Drug Abuse to investigate sensory motor development in cocaine exposed children. Dr. Arendt is also a licensed psychologist in the State of Ohio and has extensive clinical experience working with children prenatally exposed to teratogenic substances.

Amicus Curiae Marylou Behnke, M.D., is a neonatologist and Professor of Pediatrics at the University of Florida. She is the Medical Director of a regional developmental evaluation and intervention program for infants age birth to three years old with developmental disabilities. Dr. Behnke is co-principle investigator on a large prospective, longitudinal study of prenatal cocaine exposure and other factors on the development of children from ages birth to seven years old.

Amicus Curiae Maureen M. Black, Ph.D. is professor in the Department of Pediatrics and Director of the Growth and Nutrition Clinic at the University of Maryland School of Medicine. She completed her doctoral training from Emory University in Atlanta, Georgia and has served as president of the Society of Pediatric Psychology and the Division of Children, Youth and Family Services of the American Psychological Associations. Much of her research involves interventions for children with prenatal exposure to substances and she has published over 100 peer reviewed articles and chapters in

journals such as *Pediatrics*, *Child Development*, and *American Psychologist*.

Amicus Curiae Ira J. Chasnoff, M.D., is President of the Children's Research Triangle and a Professor of Clinical Pediatrics at the University of Illinois College of Medicine in Chicago. The author of four books and numerous articles, as well as the principal investigator on more than two dozen federal grants to research the effects of drug use on pregnancy, Dr. Chasnoff is one of the leading researchers in the field. His research projects include multiple studies of the long-term cognitive, developmental, behavioral and educational effects of prenatal exposure to alcohol, cocaine, and other drugs; the effects on birth outcome of prenatal treatment and counseling for pregnant drug abusers; and the effectiveness of both outpatient and residential treatment programs for pregnant drug abusers. Dr. Chasnoff is a Fellow of the American Academy of Pediatrics and the recipient of many awards.

Amicus Curiae Sterling K. Clarren, M.D., is the Robert A. Aldrich Professor of Pediatrics at the University of Washington School of Medicine where he has taught since 1978. Dr. Clarren is also the Associate Director of Inpatient Services at Seattle's Children's Hospital and Regional Medical Center, and the Medical Director of the Washington State Fetal Alcohol Syndrome Diagnostic and Prevention Network.

Amicus Curiae Claire D. Coles, Ph.D., is Director of Maternal Substance Abuse and Child Development and Professor in the Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta. She also holds a joint appointment in the Department of Pediatrics and directs the Fetal Alcohol Center at the Marcus Institute, a Division of Kennedy-Krieger Institute at Emory University, which, among other things, provides diagnostic and clinical

services to children prenatally exposed to alcohol, cocaine and other drugs.

Amicus Curiae Nancy Day, M.P.H., Ph.D., is a Professor in the Departments of Psychiatry, Epidemiology, and Pediatrics at the University of Pittsburgh School of Medicine and the Graduate School of Public Health. Dr. Day is the Director of the Maternal Health Practices and Child Development Project which address the effects of prenatal exposure to alcohol, tobacco, marijuana, and cocaine on the long-term outcome of the offspring. She has published extensively on this research and has served on government committees concerning substance abuse.

Amicus Curiae Virginia Delaney-Black, M.D., M.P.H., is neonatologist and Associate Professor of Pediatrics at Wayne State University. She also serves as the Assistant Director for Health Care Effectiveness of the Children's Research Center of Michigan, a non-profit research organization developed to assess the longitudinal effects of prenatal alcohol and cocaine on child development. Dr. Delaney-Black serves on a grant review committee of the National Institutes of Health and is the author of several articles, chapters and abstracts on drug use during pregnancy.

Amicus Curiae Fonda Davis Eyler, Ph.D., is a licensed developmental psychologist and Professor in Pediatrics at the University of Florida. She is the Developmental Director of a regional developmental evaluation and intervention program for infants birth to three years old with developmental disabilities. Dr. Eyler is co-principle investigator on a large prospective, longitudinal study that has investigated the effect of prenatal cocaine exposure and other factors on the development of a cohort of children from birth to seven years old. She has

published many journal articles and reviews and spoken at international meetings on the topic of prenatal drug exposure

Amicus Curiae Deborah A. Frank, M.D., is Associate Professor of Pediatrics at Boston University School of Medicine and Director of The Growth and Development Program at Boston Medical Center. For ten years she has been the principal investigator of a National Institute of Drug Abuse funded longitudinal study of urban children with and without *in utero* cocaine exposure. Dr. Frank has served on many scientific review committees of the National Institute of Drug Abuse and published several articles on the impact of prenatal exposure to cocaine and other threats, particularly malnutrition, to the development of low income children.

Amicus Curiae Sydney L. Hans, Ph.D., is an Associate Professor of Psychiatry at the University of Chicago. For over twenty years Dr. Hans has investigated the consequences of mothers' substance abuse on parenting behavior and the development of children. Dr. Hans is the principal investigator of the only long-term study that has followed infants prenatally exposed to drugs through adolescence.

Amicus Curiae Hallam Hurt, M.D., is Chairman, Division of Neonatology, Albert Einstein Medical Center in Philadelphia. For the past twenty years, Dr. Hurt has cared for thousands of mothers and infants from inner-city Philadelphia. In the late 1980s, she undertook what has become one of the longest-running studies of children with *in utero* cocaine exposure. In a series of publications, she has discussed her data suggesting that children raised in the inner-city are at risk for suffering cognitive deficits regardless of *in utero* exposure to cocaine.

Amicus Curiae Joseph L. Jacobson, J.D., Ph.D., is Professor of Psychology in the College of Science, Wayne State University. Dr. Jacobson's research on the effects of prenatal exposure to neurotoxic agents on intellectual and behavioral development in childhood has been funded by the National Institutes of Health and published in, among other periodicals, the *New England Journal of Medicine*, *Journal of Pediatrics*, and *American Journal of Public Health*.

Amicus Curiae Helen Johnson, Ph.D., is Professor and Chairperson in the Department of Elementary and Early Childhood Education at Queens College of the City University of New York. For the past 20 years, Dr. Johnson has conducted longitudinal neurobehavioral research, funded by the National Institute on Drug Abuse, examining the development of children born to women who abused drugs during pregnancy. Dr. Johnson has published findings from this work in peer-reviewed journals including *American Journal of Orthopsychiatry*, *Early Development and Care*, *Infant Behavior and Development*, and *Journal of Genetic Psychology*, and has presented the data to many national and international organizations including *American Orthopsychiatric Association*, *American Psychological Association*, *International Society for Infant Studies*, and *National Association for the Education of Young Children*.

Amicus Curiae Stephen Kandall, M.D., served as Chief of Neonatology at Beth Israel Medical Center from 1976 to 1998. As a clinician and researcher, Dr. Kandall has written widely in the area of perinatal drug use. He is author of SUBSTANCE AND SHADOW, WOMEN AND ADDICTION IN THE UNITED STATES and has contributed chapters to many standard textbooks, including SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK AND PRINCIPLES OF ADDICTION MEDICINE. Dr. Kandall was named by *New York Magazine* as one of New York

City's best doctors in both Newborn Medicine and Addiction Medicine.

Amicus Curiae Bernard Z. Karmel, Ph.D., is head of the Neurophysiological Development Laboratory in the Infant Development Department of the New York State Institute for Basic Research in Developmental Disabilities, Staten Island, NY. He also is an adjunct Professor in the Developmental Neuroscience Program of the Biology Department of the City University of New York. He is internationally known for his research on early infant attention and brain-behavior relationships. Dr. Karmel's most recent research has concentrated on early infant neurobehavioral and neurophysiological development in infants assigned to the Neonatal Intensive Care Unit at birth or who were exposed to drugs of abuse *in utero* such as cocaine.

Amicus Curiae Nancy Kass, Sc.D., is Associate Professor and Director of the Program in Law, Ethics, and Health, Johns Hopkins School of Public Health, Associate Professor in the Bioethics Institute, Johns Hopkins University, and a Fellow of the Kennedy Institute of Ethics, Georgetown University. Dr. Kass conducts empirical research in bioethics and health policy, with a focus on matters of confidentiality. She is coeditor of HIV, AIDS and Childbearing: Public Policy, Private Lives (Oxford University Press, 1996).

Amicus Curiae Barry E. Kosofsky, M.D., Ph.D., is the Director of the Laboratory of Molecular and Developmental Neuroscience at Massachusetts General Hospital and is an Associate Professor of Neurology at Harvard Medical School. Dr. Kosofsky also serves as the Director of Substances of Abuse Exposure Follow-up Clinic. He has provided longitudinal care for infants, children and adolescents with developmental, neurologic, and academic compromise secondary to gestational

exposure to drugs of abuse. In addition, Dr. Kosofsky has conducted extensive research on the structural and functional effects of prenatal cocaine exposure on mouse brain development.

Amicus Curiae Barry M. Lester, Ph.D., is Professor of Psychiatry and Human Development and Professor of Pediatrics at the Brown University School of Medicine. He is Director of the Infant Development Center at Women and Infants Hospital, providing research and clinical services for infants at risk and their families. Dr. Lester is the principal investigator on grants from the National Institutes of Health and the Robert Woods Johnson Foundation for prenatal drug exposure and child outcome.

Amicus Curiae Robert David Needlman, M.D., is Associate Professor of Pediatrics at Case Western Reserve University School of Medicine. Dr. Needlman is also an attending physician at Rainbow Babies and Children's Hospital, and has published extensively on prenatal healthcare and the consequences of cocaine use on child development.

Amicus Curiae Daniel R. Neuspiel, M.D., M.P.H., is Associate Chairman of Pediatrics and Associate Medical Director at Beth Israel Medical Center in New York City. He is also Associate Professor of Pediatrics and of Epidemiology and Social Medicine at the Albert Einstein College of Medicine. Dr. Neuspiel is certified in pediatrics, preventive medicine and addiction medicine. Dr. Neuspiel has conducted research on developed clinical programs for women who use cocaine and their children.

Amicus Curiae Robert G. Newman, M.D., is President and Chief Executive Officer of Continuum Health Partners, Inc., comprising four hospitals with a total of 3,100 beds, and with

the largest chemical dependency treatment services of any health care system in the United States. He is Professor of Epidemiology and Social Medicine and Professor of Psychiatry at the Albert Einstein College of Medicine, and a member of the Board of Commissioners of the Joint Commission of Accreditation of Health Care Organizations. Dr. Newman has played a major role in the development of addiction treatment in the U.S., Australia, Asia and Europe.

Amicus Curiae Gale A. Richardson, Ph.D., received her Ph.D. in Developmental Psychology from West Virginia University and is currently an Associate Professor of Psychiatry and Epidemiology at the University of Pittsburgh. She is the Principal Investigator of an NIDA-funded investigation of the long-term effects of prenatal cocaine exposure on child development.

Amicus Curiae Lynn T. Singer, Ph.D., is Professor of Pediatrics and Psychiatry, Case Western Reserve University School of Medicine, Cleveland, Ohio. Dr. Singer is a licensed psychologist who is the principal investigator of two major longitudinal studies of high risk infants funded by the National Institutes of Health and the Maternal and Child Health Service Bureau, one of which is following a large cohort of cocaine-polydrug exposed infants longitudinally. Dr. Singer has published extensively in this area.

Amicus Curiae Robert J. Sokol, M.D., is Director of the C.S. Mott Center for Human Growth and Development, Professor of Obstetrics and Gynecology, and former Dean of the Wayne State University School of Medicine, as well as former Senior Vice President for Medical Affairs of the Detroit Medical Center. Dr. Sokol has conducted research and written widely in the field of prenatal substance exposure and its neurobehavioral impact on offspring.

Amicus Curiae Edward Tronick, Ph.D., is an Associate Professor of Pediatrics at Harvard Medical School and an Associate Professor of Maternal and Child Health at the Harvard School of Public Health. He is Chief of the Child Development Unit at Children's Hospital, Boston, Massachusetts. Dr. Tronick has studied the effects of cocaine and other toxic substances on the neurobehavioral organization of infants and young children, and is the author of numerous scientific articles on this issue.